

**The SSA
intermediary
function**

1972 Annual Report of the
Division of Direct Reimbursement

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Division of Direct Reimbursement

Annual Report 1972

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Foreword

For the Division of Direct Reimbursement, FY 1972 was a very good year; one of significant changes and one that marked the beginnings of several important projects.

I am especially proud of the performance of the entire staff in handling the increased claims workloads which were experienced in FY 1972. This was a particularly critical period, since the increases occurred during a time of staffing limitations. Through greater effort, the staff managed the increased workload and even significantly improved upon their already commendable claims processing time. While we anticipate further workload increases as the trend of FY 1972 continues into the upcoming fiscal year, I am confident that we will continue to meet the challenge and build upon the accomplishments already achieved.

*Albert Fox
Director, Division of
Direct Reimbursement*

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Introduction

The Division of Direct Reimbursement (DDR), Bureau of Health Insurance, Social Security Administration (SSA), serves on behalf of the Government as the Medicare fiscal intermediary for providers of health services. In this capacity, DDR serves any provider which is certified to participate in the program and desires to deal directly with SSA.

At present more than 640 providers deal directly with the Government (DDR). These direct dealing providers (DDP's) represent approximately three percent of all providers participating in the Medicare program. They include each type of health facility: hospitals, extended care facilities (ECF's), home health agencies (HHA's), and rehabilitation or "physical therapy centers" (PT's). They are widely dispersed among 34 States, the District of Columbia, and Puerto Rico, and provide multiple levels of care (not all of which are covered by Medicare). Also, approximately 80% of all DDP's are State- or municipally-controlled providers, and include 9 State hospital systems, Saint Elizabeth's Hospital in the District of Columbia, Puerto Rico's hospital system, New York City's hospital system, and 4 State home health systems. DDR also serves as the fiscal intermediary for approximately 418 Department of Defense, Public Health Service, and Veterans Administration hospitals, which participate in the capacity of Federal emergency hospitals.

Type of Provider	State/ Municipal Other		Total
Hospital	173	33	206
ECF	13	65	78
HHA	349	12	361
PT	0	4	4
Total	535	114	649
Federal Emergency			
Hospital	418	0	418
Grand Total	953	114	1067

In addition to its intermediary responsibilities, DDR serves as the Part B carrier for 8 of the direct-dealing State hospital systems, Saint Elizabeth's Hospital, the New York City hospital system, 2 Pennsylvania tuberculosis hospitals, and the Federal emergency hospitals. DDR also services 29 direct-dealing group practice prepayment plans (GPPP's).

During fiscal year (FY) 1972, DDR developed and implemented a number of refinements to improve its claims processing operation. One such improvement was the conversion of some of the manual systems to computer systems to further consolidate the overall operation. DDR has also initiated special efforts during FY '72 to assist providers with their unique problems. These and other efforts are covered in greater detail in the following highlights of DDR's present and projected endeavors.

Group Practice Prepayment Plans

The Group Practice Prepayment Plan Branch of DDR has responsibility for formulating reimbursement guidelines for carrier-dealing and direct-dealing group practice prepayment plans (GPPP's). It also has responsibility for authorizing Part B reimbursement for the direct-dealing GPPP's. The GPPP Branch is currently paying direct-dealing GPPP's approximately \$32,100,-

000 per year for the plans' 285,015 Medicare beneficiaries. The chart set out below illustrates the number of plans participating during each fiscal year beginning with FY 1967, together with the amounts of reimbursement made for special administrative costs, Part B benefits, and total payments made during each fiscal year.

FY	No. of GPPP's	No. of Beneficiaries	Special Adm. Costs	Part B Benefits	Total Payments
1967	32	237,615	\$743,703	\$13,658,992	\$14,402,695
1968	30	253,830	\$586,417	\$22,105,000	\$22,691,417
1969	29	269,792	\$501,319	\$26,378,000	\$26,879,319
1970	29	277,563	\$458,710	\$27,141,000	\$27,599,710
1971	28	283,303	\$550,000	\$27,851,164	\$28,301,164
1972	29	285,015	\$600,000	\$31,500,596	\$32,100,596

Each GPPP must submit 2 cost reports: one covering their administrative costs during a Government Fiscal Year (this report becomes due on July 1 of each year), and one covering their Part B medical benefit disbursement during their fiscal year. During the 6-year period from July 1, 1966 through June 30, 1972, we have received 258 of the reports due, and have reached a settlement on 162 of these. The remaining 96 are in the process of being reviewed, audited, or negotiated for settlement.

Fiscal Year:	67	68	69	70	71	72	Total
Due:	19	53	51	53	53	54	283
Outstanding:	0	0	0	1	3	27	25

Note: With respect to the one report overdue from FY 1970 and the three reports overdue from FY 1971, we have been working closely with the three GPPP's concerned. In two cases, all payments to the GPPP's were stopped due to their failure to submit reports. In the third case, we have agreed to grant the GPPP an extension in the interests of having a report based on actual audit findings.

Intermediary Operations

Intermediary Performance

Based on the Intermediary Workload Performance Report compiled by SSA's Office of Research and Statistics, DDR handled approximately 1.5 percent of the national Part A claims processing workload (percentage based on data prior to FY 1972; similar data for FY 1972 was not available for this report), which ranks it as 14th among some 160 intermediary processing centers.

Relative Size Prior to Fiscal Year 1972		
Ranking	Intermediary	Percent of Part A National Workload
1.	Illinois-Chicago B/C	5.1 ¹
10.	Indiana B/C	2.3
11.	North Carolina B/C	1.9
12.	Pennsylvania-Intercounty	1.8
13.	Kentucky B/C	1.7
14.	<i>Division of Direct Reimbursement</i>	1.5 ²
14.	New Jersey B/C	1.5
15.	Tennessee-Chattanooga B/C	1.4
16.	Alabama B/C	1.3
16.	Maryland-Baltimore B/C	1.3
17.	Iowa-Des Moines B/C	1.2
17.	Washington-Seattle B/C	1.2

¹ Largest intermediary in the country.

² Represents Part A workload only; however, DDR's Part A claims workload only accounts for approximately 60 percent of the total claims it processes. The balance of 40 percent represents the processing of Part B claims for provider-based physicians' services.

During the first half of FY 1972, DDR processed 1.62 Part A intermediary claims per man-hour at a cost of \$3.68 per claim. When

the carrier (Part B) workload was included, DDR had processed 2.94 claims per man-hour at a cost of \$2.04 per claim overall.

DDR has realized a slight decrease in the number of direct-dealing providers, while experiencing an increase in the claims workload during FY 1972. This is reflected in the chart below.

FY	Hosp.	ECF	HHA	PT	Total ¹	Bills	Money
67	202	37	30 ²	—	269	116,237	\$ 39.5
68	237	29	27 ²	—	293	297,607	69.1
69	239	44	26 ²	1	310	492,595	110.3
70	228	50	392	4	674	382,640 ¹	94.6
71	213	86	391	6	696	696,137	104.8
72	206	78	261	4	649	1,293,587	109.0

(All money figures shown in millions.)

¹ As of June 30 each fiscal year.

² There were about 334 HHA units reporting to a central office which were not included in these FY statistics.

³ The decrease in the number of provider billings from FY 1969 to FY 1970 can be accounted for by a delay in providers' submission of Part B tape billings; i.e., 102 received during FY 1970 as compared to 120,000 received during FY 1969. Such billings are now being received and processed on a regular basis.

Intermediary Functions

Involved in DDR's intermediary function are four major processing categories: the Admission Notice/Response System, the Part A Processing System, the Part B Processing System, and provider cost reports. The following are highlights of DDR's progress and activities in each category.

The Admission Notice/Response System

Refinement of the basic system established in FY 1971 continued in FY 1972. In addition to varied minor and technical refinements and modifications, several significant features were added to the system:

- The Bill Submittal Notice system was refined to include both quality and time frame

controls implemented in September 1971. This system is designed to validate the accuracy of transmissions, promote more timely billing, and assist in identifying aged cases delayed in the processing operations for various reasons, which will permit more expeditious handling of such cases. Improvement in our ability to close open items, particularly blocking open items, will be reflected in more accurate and timely responses to subsequent admissions.

- DDR implemented its own provider address tape for use in preparing the Form SSA-1568, Reply to Notice of Admission. Previously, DDR had been dependent upon the use of SSA's master health insurance provider tape. Establishment of the separate address file provides a more complete and current file, and permits use of special mailing addresses in cases where several providers operate through a central office. This feature also reduces the amount of clerical work needed to process the forms for mailing.

- A comprehensive, computer-generated monthly report of Part A query/response activity was initiated in January 1972. The report provides administrative and workload data for use by DDR personnel and direct-dealing specialists in the HI regional offices. The report also provides data for identifying problem areas, such as untimely submission of admission notices by a provider or Social Security Office (SSO), and for evaluating provider, SSO, and DDR performance by statistically depicting consistently abnormal processing patterns.

- Expanded and refined computer edits were added to the Advanced Record System which is used for transmitting direct-dealing provider admission data to SSA. The revisions were designed to reduce DDR's clerical activity in investigation and resolving incomplete or incorrect admission and start-of-care notices. In conjunction with this feature, SSO responsibilities for review and transmission were expanded, and revised instructions were issued. The total effort is expected to result in more accurate and complete transmissions, tighter control, faster responses, and less clerical work in DDR. Additional features being planned and de-

veloped provide for more selective issuance of Bill Submittal Notices, electronic preparation of beneficiary disallowance notices at admission, and technical refinements to further reduce clerical investigation and development activities.

Part A Processing System

Emphasis in the first half of this fiscal year was on validation and refinement of the revised system which had been implemented in the last quarter of FY 1971. A number of technical refinements and modifications, all designed to provide more complete and accurate editing of claims prior to payment, were instituted. Additional changes, such as combining the payment and admission notice address files, and the Part A and Part B reimbursement rate tables, were made to improve the efficiency of our electronic systems.

Planning and development were undertaken on several features which are planned for implementation in FY 1973. These include preparation of a provider data report (primarily for use by the accounting staff), establishment of screening parameters within the EDP system, and expansion of the control system to provide for more complete electronic control of all claims.

Work has continued on our development of specifications to accept claims data on magnetic tape from providers. Before specific and final specifications can be established, however, projects such as the electronic edits must be implemented and validated. We are continuing to work with providers to assist them in their ability to submit computer-prepared claims forms as a step to submittal of claims data on magnetic tape.

Some specific activities in the Part A Processing System which took place during FY 1972:

Utilization Review: During the latter half of FY 1972, DDR conducted a review of the operating procedures and goals of its Utilization Review Committee. The review resulted in a modification of the operating procedures of the group, which will now be known as the Medical Review Staff (MRS). It is believed that the changes will enable DDR to make more effective use of its consultants' medical expertise in achieving the following goals:

- Identify and investigate questionable patterns of practice (utilization);
- Develop improved methods of utilization review to enhance MRS's capability to serve as an advisor to direct-dealing providers;
- Identify and investigate internal DDR medical review procedures for the purpose of recommending possible improvements, and fostering uniform application of existing guidelines and instructions.

Achievement of the stated goals will be greatly enhanced when DDR's computer system is capable of generating meaningful utilization data for use by the MRS. However, such capability is not expected before FY 1974.

Provider Training: DDR is engaged on an ongoing basis in providing support to HI regional offices so that they may better perform the necessary training of direct-dealing providers. One element of such support is the preparation of training and survey guides for use during provider visits by regional office personnel. The guides should be completed in early FY 1973. DDR has also worked very closely with groups of providers which have encountered special problems while participating in the program. With the full cooperation of the providers, concentrated efforts have been undertaken to foster better understanding of the level of care which must be present in order that the care rendered to patients be considered active care as well as to improve the quality of claims preparation.

Diagnostic Screening Guides: The present guides have been updated in accordance with patterns established by provider billings. However, a much more comprehensive guide is being developed for electronic application. (See "Part A Processing System" on Page 7.)

Drugs: The development of a new drug formulary, with a therapeutic utilization category and unit selling price, is continuing. DDR's drug consultant is nearing completion of a survey of the types of drugs actually used in direct-dealing ECF's, drug costs, and source of drug purchases. It is still too early for any firm conclusions. Completion of the study is expected during the latter half of FY 1973. Upon completion, it is anticipated that this formulary may be utilized by both lay examiners and medical review technicians. By using this formulary, DDR hopes to be able to ensure on initial re-

view that providers are following proper utilization practices, and also to obtain the identification of any providers that do not appear to be adhering to the "prudent buyer" concept.

The drug consultant also conducts an ongoing random sample review, by provider, in order to identify any patterns of drug utilization and purchasing which require contact with the provider.

HHA Billing: DDR serves as intermediary for more than 360 home health agencies. The HHA's include proprietary agencies and the county agencies comprising the State systems in Alabama, Arkansas, Pennsylvania, and Virginia. Our efforts to ensure consistent application of home health coverage guidelines by HHA's continues to be an ongoing project. A number of agencies have long been geared to the concept of public health nursing which is frequently "preventive maintenance" nursing and not covered by Medicare.

An extensive training effort by DDR during FY 1972 has resulted in greater awareness on the part of direct-dealing HHA's as to which services are covered and which are not. This training effort is being continued on an ongoing basis.

ECF Billing: DDR serves as intermediary for 65 extended care facilities, accounting for approximately 5 percent of the total DDR Part A workload. This remains a critical area. After several years of program operation, ECF's still encounter real difficulty in understanding and applying the ECF "level of care" requirements. DDR has continued to promote provider understanding and application of coverage guidelines through orientation and follow-up visits by DDR medical and regional office (HIRO) personnel. Such visits have also been supplemented with telephone discussions of specific cases between DDR and provider medical personnel. The high turnover of personnel experienced by ECF's tends to make such special efforts a continuing task.

Psychiatric Billing: Twenty percent of all participating psychiatric hospitals deal directly with DDR. Most direct-dealing psychiatric hospitals are a part of the State hospital systems of Arizona, California, Georgia, Minnesota, New York, Ohio, Utah, and Washington. These are generally large, state-funded institutions. They provide multiple levels of care, a fact

which often poses problems in determining the Medicare coverage status of their patients.

Significant advances were made during FY 1972. With the assistance of its consulting psychiatrist, DDR conducted a training program which resulted in better provider understanding and improved pre-submittal screening of claims for covered services. However, there is still considerable room for improvement.

Intermediary Bill Validation: Validation studies were conducted during FY 1972 to assure that services billed to DDR had, in fact, been rendered by direct-dealing providers. A sampling of provider bills that had been processed and paid were turned over to DDR personnel who, on regularly scheduled visits, checked the providers' records to verify whether the services, in question, had been rendered. The same bills were also sent to HI regional offices for contact with the beneficiaries involved to verify whether such services had been received. If either the provider's records or the beneficiary contacts indicated any inconsistency, further investigation was undertaken. This procedure is presently being used on an ad hoc basis only.

Part B Processing System

In January 1972, a revised system was implemented which would provide for greater application of computer operations to the bill review, query, and payment operations. The basic features included:

- Punching of all bill data (except medical) from Forms SSA-1483 and SSA-1554 and transfer of Part B SSA-1487's from the Part A to the Part B system;
- Electronic editing of bill data (consistency edits);
- Automatic query for Part B entitlement and deductible status, and electronic control of queries;
- Electronic editing of bill data to utilization records;
- Electronic duplicate claim check after query and utilization checks but prior to payment;
- Electronic computation of reimbursement, utilizing reimbursement rate tables within the system; and,
- Submittal of claims data on magnetic tape to the master health insurance system.

Various technical refinements and modifications have already been made, and studies are continuing to identify the need for additional improvements. Among features already identified for improvement are: a change to performing the duplicate claim check prior to query, and computer-generation of disallowance notices under certain circumstances.

In addition to the primary processing system, a sub-system is in operation for processing on an experimental basis outpatient clinic billing submitted on magnetic tape. Modifications to the sub-system are being developed to establish a continuing scientific sampling of the claims intended to ensure that proper documentation is being maintained by the providers.

Provider Cost Reports and Audits

The Division services approximately 345 active provider cost centers filing annual cost reports for which final settlement must be made. For the 6-year period of July 1, 1966 through June 30, 1972, there were 1,770 cost reports due in the Division. For this same 6-year period, DDR has received 1,404 cost reports. Upon receipt, each cost report is desk reviewed, tentative settlement made, and a determination made as to the extent of audit. Of the 1,404 cost reports received through June 30, 1972, desk reviews have been completed on 1,197 of which 1,009 have been forwarded for audit or have been audited. Audits were waived on the remaining 188. Final settlements have been made on 571 reports.

	FY 67 FY 68 FY 69 FY 70 FY 71 FY 72 Totals									
Hosp.	193	227	227	225	220	213	1,305			
ECF	9	34	34	39	55	89	206			
HHA	21	24	28	34	44	38	189			
PT	—	—	1	3	6	6	16			
Total	223	285	290	301	325	346	1,404			
Outstanding	0	0	0	1	126	229	366			

During FY 1972, DDR arranged with the DHEW Audit Agency to take over the function of contracting for audits of direct-dealing providers. Accordingly, when a DDR accountant decides that an audit is required, he must complete an "Audit Guide" survey. When completed, this Guide is a comprehensive evaluation of

the provider's financial records and is made available to the prospective audit subcontractors. The evaluation provides the various audit firms with as much information as possible concerning the provider's financial operation so that the firms can submit realistic cost proposals. As contracts are awarded and audits performed, the DDR accountant servicing the provider undergoing audit acts as the "Project Officer" of the audit contract. The "Project Officer" is required to: (1) review the biweekly progress reports prepared by the auditing firm and keep track of the administrative and financial progress of the audit; and (2) complete an evaluation of the audit firm's performance by reviewing their workpapers in order to determine the overall quality of the audit.

Another new area of responsibility is the implementation of the economic stabilization (Phase 2) regulations. In effect, the Division is required to monitor its providers for compliance with economic stabilization wage and price rules in order to insure that final cost reimbursement is in compliance with the allowable percentage increases.

Also during FY 1972, DDR's Provider-Based Physician Specialists (PBPS) have established provider-based physician files which identify

all providers serviced by DDR's carrier operation, and have documented all available information and data concerning the allocation of physicians' time and salaries. DDR has been reviewing and auditing the Part B per diem rates presently being paid to determine the propriety of per diem computations and the bases upon which these rates were established. Much work remains to complete verification of the established rates and to maintain provider-based physician information.

DDR is currently in the process of establishing the machinery to process provider appeals in accordance with the recently issued regulations. DDR expects its proposed system to become operational during the first half of FY 1973.

Internal Quality Appraisal

DDR is presently refining its internal quality control system for better utilization of techniques to measure and evaluate the overall effectiveness of DDR as an intermediary operation. These improvements will also enhance DDR's ability to measure the performance of its personnel in adhering to existing guidelines and instructions.



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